Mental Health Support of Police Negotiator Program

Model of Service

March 2017

Queensland Government

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For more information contact:
Queensland Forensic Mental Health Service, Metro North Hospital and Health Service, GPO Box 8161, Brisbane QLD 4001, phone 3837 5820.

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Background

Interactions between police and individuals who have a mental health problem occur frequently and the frequency of these occurrences in Queensland is estimated to be similar to other Australian jurisdictions. For example, in 2014/15, the Queensland Police Service (QPS) received 24,416 calls for service as mental health incident types and acted under the *Mental Health Act 2000* on 13,065 occasions[1]. In 2013, New South Wales (NSW) police responded to 42,800 mental health related incidents[2] while in 2009/10 in Victoria, a transfer by police under the now-repealed *Mental Health Act 1986 (Vic)* occurred approximately every two hours[3].

Police interactions with persons in crises in the community can result in first response officers acting as a pivotal point of contact to engage individuals that require mental health intervention[4]. While these situations are usually managed successfully, they can be challenging for all parties involved and on rare occasions can result in tragic outcomes. The mentally ill, for example, are overrepresented in fatalities resulting from police shootings[5]. From 1989/90 to 2010/11, there were 105 persons fatally shot by police nationally and of these, 44 (42%) were identified as having a mental illness[6].

More recently, there have been a number of high profile incidents involving police and persons with mental illness. For example, in Queensland in 2014, four people died as a result of police shootings within a one month period[7], and in June 2016, media reports detailed the NSW police shooting of a patient who was on approved leave from a mental health service at the time of the incident[8]. Other challenging circumstances that may involve police and the mentally ill are siege situations, which can be complex, time consuming and highlight the importance of co-ordinated collaboration between departments[9].

In Queensland, there are approximately 200 events per annum that involve the use of QPS police negotiators. These events range from responding to crisis situations, including attempted suicides, to barricade and hostage situations. Itis estimated that nearly 85% of individuals who become the subject of a negotiation incident have been open consumers in the past, or are currently open consumers of mental health services. Coordination of resources and expertise across government is imperative in these complex situations and requires enhanced communication, information sharing and collaborative relationships across relevant agencies.

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[1] QPS unpublished data. (2015).
[2] http://www.police.nsw.gov.au/community_issues/mental_health
[3] Short, T. B. R., MacDonald, C., Luebbers, S., Ogloff, J. R. P., & Thomas, S. D. M. (2014).
[4] Ogloff, Davis, Rivers, & Ross (2007).
[5] Kesic, D., Thomas, S. D. M., & Ogloff, J. R. P. (2010).
[6] Australian Institute of Criminology. (2013).
[7] http://statements.qld.gov.au/Statement/2015/5/8/clinical-review-to-examine-serious-mental-health-events
[8] http://www.abc.net.au/news/2016-06-10/hornsby-shooting-jerry-sourian%27s-father-says-police-mishandled/7501536
[9] Commonwealth of Australia. (2015).

Model elements

A number of models for mental health service support for police negotiators operate nationally and internationally. These models primarily focus on general collaboration and first response options, rather than specific programs developed for crisis negotiation responses.

Ideally, police and mental health collaboration should be embedded in an integrated manner throughout each organisation. This integration serves to ensure collaboration across agencies is undertaken as part of normal business, rather than being an exception for specific circumstances. Collaboration at all levels of police and mental health agencies can occur through a range of mechanisms that include enhanced training and education, co-responder models where police and mental health work together as part of a multi-disciplinary team, clear and consistent information sharing processes and pathways, and well-defined governance structures that include senior and executive officers.

In terms of specific models for mental health service support for police negotiators, four key functions are identified in the literature; 1) consultation/advisory, 2) integrated mental health/police team, 3) mental health negotiator, and 4) mental health lead[10].

Consultation and integrated team models operate to enhance police understanding about mental illness and the mental health system, while the mental health negotiator and mental health lead models require mental health clinicians to directly undertake, or order, the functions of police negotiators.

There are a number of risks associated with mental health clinicians taking lead roles in police negotiations. These risks arise from differences in scope of practice, expertise and training across the mental health and police sectors. A lack of role clarity and a potential for confusion regarding governance and reporting responsibilities can also arise if mental health clinicians take the lead role in police practices. This can impact on the relationships between the police and mental health sectors and may create ethical challenges for clinicians in circumstances where the use of force or deception is required to resolve the crisis or siege situation. For these reasons, despite acknowledging that models of mental health service support could include utilising mental health clinicians as negotiators or undertaking a lead role, the literature strongly advises against these models[11]. Instead, consultation or integrated models for mental health support to police negotiators are promoted.

While the integrated and consultation models differ in terms of governance and workforce, there are a number of consistent functions for mental health clinicians that these models may incorporate[12]:

- during the event:
    - provision of advice regarding mental illness
    - provision of advice regarding effects of drugs or alcohol

[10] Hatcher, C., Mohandie, K., Turner, J., & Gelles, M. G. (1998).
[11] Ibid.
[12] Ibid; Feldmann, T. (2004); Fisher, M. & Ireland, C. A. (2010).

- strategies to reduce stress for negotiators and the relevant person the subject of the interaction
- provision of advice regarding responding to, or management of, reactions of the relevant person the subject of the interaction (including paranoid or depressive reactions), and
- assessment of risk factors
- advice regarding behaviours/stressors relevant to victims, family members or affected members of the community, and
- obtaining collateral information.

- prior to and post the event:
  - referrals to mental health services for relevant person the subject of the negotiation, victims, police
  - debriefing police negotiators
  - input into training and education
  - service development, recruitment strategies, and
  - research.

In addition to considering the types of support that may be offered to police negotiators, research indicates that the type of information that may be shared across health and police organisations is also important. Information sharing between police and health organisations can support effective collaborative relationships that improve outcomes for consumers[13], however if the information is not pertinent to the police carrying out their functions it may be of little value. For example, although advising that "patient X last received mental health services six months ago, they have a diagnosis of schizophrenia and they are prescribed risperidone (anti-psychotic medication)" may be meaningful for clinicians, it may not be relevant to the police response in a crisis situation.

It has been well-established in coronial reviews of police shootings that determinations that a person had a mental illness at the time of the fatality is indicative of the presence of the illness only, and does not by itself, indicate that the person was unwell or displaying symptoms of mental illness at the time of police interaction[14]. Further, the provision of advice about the person's diagnosis and/or medication without contextual information and interpretation for police is unlikely to be of assistance in determining how police can best to respond to the relevant person.

The final consideration for a model of mental health service support for police negotiators is an acknowledgement that multiple determinants impact outcomes for police negotiations involving persons with mental illness. The complex nature of these interactions may result in negotiations not being resolved peacefully, despite the best efforts of both police and mental health services[15]. However, through collaboration the

[13] Stevenson, C., McDonnell, S., Lennox, C., Shaw, J., & Senior, J. (2011).
[14] Australian Institute of Criminology, 2013.
[15] Mohandie, K., & Meloy, J. R., 2010.

risks of such outcomes are reduced and chances of better outcomes for individuals and services are enhanced.

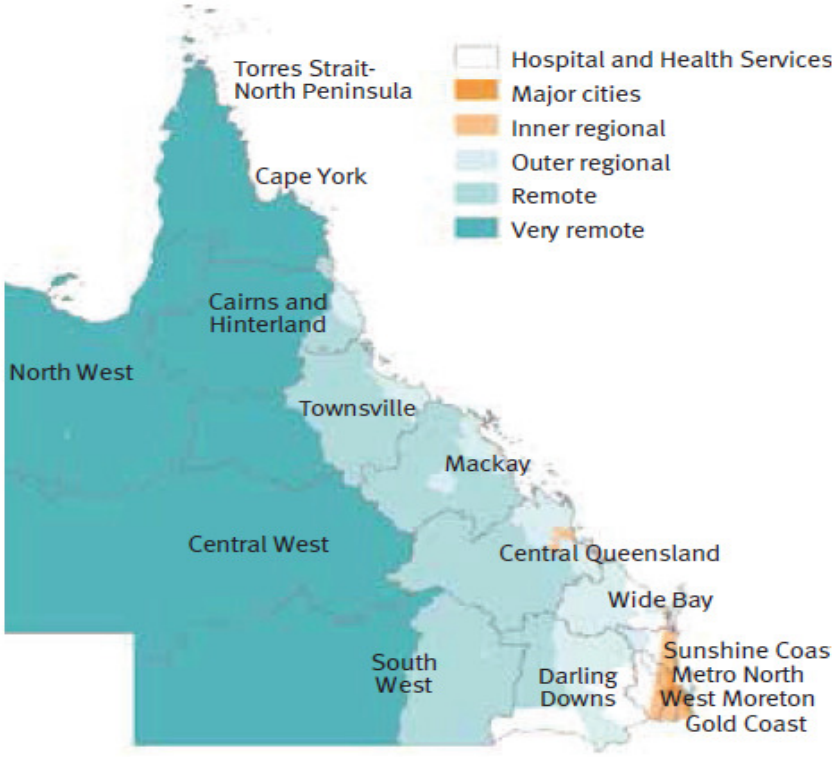
Queensland Context

In terms of police negotiators practices in Queensland, interactions between police and persons with a mental illness can range from crisis situations, including attempted suicides, to barricade and hostage situations. In the past mental health input into these situations has occurred in an ad-hoc manner. For example, mental health input may be undertaken by local clinicians providing limited information under a Memorandum of Understanding, or may include clinicians attending (in rare circumstances) the site where the police negotiation is occurring. The ad-hoc involvement of mental health services has created operational challenges for the QPS and mental health services. This has included who to contact within the mental health system; how best to initiate contact; how to obtain relevant information and support; and managing expectations regarding the type of response provided by mental health clinicians and the information that can be shared.

An important consideration for Queensland in developing a model of service to support police negotiators is the uniquely dispersed population. Approximately 70% of people reside in the capital city in all Australian jurisdictions other than Queensland, where just over half of the population lives outside of the capital city (52% reside outside of Brisbane)[16]. The Queensland population is primarily clustered in major cities or inner regional areas (82%); however 15% live in outer regional areas and 3.1% live in remote or very remote areas (Figure 1)[17]. Although the QPS operates through a centralised model of governance, there are 16 independent Hospital and Health Services (HHSs) that operate across Queensland, all of which provide mental health service support.

[16] Queensland Health, 2014
[17] Ibid.

Figure 1: Queensland by remoteness areas and HHS*



**Torres Strait-Northern Peninsula and Cape York HHS are amalgamated. Children's Health Queensland operates as a specialist child and youth HHS.*[18]

Given this context, mental health service support to police negotiators may be delivered through a number of mechanisms in Queensland. These mechanisms may rely on enhancement of local relationships between police and mental health services or the development of a centrally managed process within the Queensland Forensic Mental Health Service (QFMHS).

The model of service outlined below envisages a centrally managed contact point for police (through the QFMHS) that then links with mental health services at the local level and other important programs and services that involve that link mental health services, police and the criminal justice system, such as the Mental Health Intervention Program, Court and Prison Mental Health Services and Acute Care Teams. The liaison model ensures that expertise and resources are used in the most efficient manner, whereby local services maintain carriage of the person's treatment and care and the QFMHS is available to support these services and to facilitate communication and liaison across police and mental health services. The use of existing Queensland Health (QH) resources through this liaison and support model also ensures that standardised processes and practices can be established in relation to providing mental health service support to the QPS.

[18] Queensland Health (2014).

Proposed Model of Service – Mental Health Service Support of Police Negotiator Program

Key definitions

Negotiation Incidents includes any incidents that may be responded to by police negotiators in Queensland. This includes, but is not limited to, incidents involving suicide interventions, barricade sieges and hostage sieges.

Aims of providing mental health service support

The primary aim of providing mental health service support to police negotiators is to enhance outcomes for mental health consumers and reduce risks for consumers, police and others that are involved in crisis situations that occur in the community. This aim is to be achieved through enabling strong collaboration between the mental health system and the police negotiators. It is intended that mental health service support be provided through existing mechanisms available within the QMHFS and authorised mental health services; and be guided by a model of service that enables support to be provided in a systematic and coordinated manner.

This model of service does not limit the ability of QPS officers to obtain information or support through alternative mechanisms, for example through co-responder programs or Mental Health Intervention Coordinators.

Overarching principles

The provision of support by mental health services during an incident requiring police negotiation is guided by a set of principles that have been agreed across the QPS and QH. These principles acknowledge and respect the organisational expertise, goals and boundaries of the QPS and QH, and support approaches that enhance collaborative relationships.

Principle 1. It is the Queensland Police Service's responsibility to respond to crisis situations in the community where there is a risk of harm to the person or others.

Principle 2. Queensland Health mental health services provide support to people experiencing mental health concerns, including by providing assessment, treatment and care services.

Principle 3. Police lead the response to Negotiation Incidents. Queensland Health mental health service clinicians provide mental health service support but should not be involved in making tactical decisions.

Principle 4. Queensland Health mental health services support police negotiators by undertaking the following functions:

- provision of general advice regarding mental illness and drugs and alcohol issues.
- obtaining and sharing relevant collateral and historical information, and

- undertaking assessment and providing follow up treatment and care when indicated.

What support does the mental health service provide?

The provision of support to police negotiators leverages off existing mental health services within the QFMHS and HHSs and augments these with a specialist on-call forensic psychiatry service located within the QFMHS and an expanded role for the Police Communications Centre Mental Health Liaison Service (PCC MHL Service).

The provision of support is outlined below and at Figure 2.

Request for support

All requests for mental health service support by police negotiators are to be initiated through a dedicated phone line that will be operationally managed across the PCC MHL service and the QFMHS on-call psychiatry roster. Generally, the PCC MHL clinician will be the first point of contact; however the QFMHS-on-call psychiatrist will be the first point of contact when the PCC MHL clinician is not on shift.

Handover between the PCC MHL clinician and the QFMHS-on-call psychiatrist:

- If the PCC MHL clinician has responded to the police negotiator request for support, they must ensure that a handover is provided to the QFMHS-on-call psychiatrist for any Negotiation Incidents that may continue beyond the clinician's shift. This handover should be provided at least one hour prior to the clinician finishing their shift to ensure sufficient time for the QFMHS-on-call psychiatrist to review any documentation that may be relevant should ongoing mental health service support be required.

- In addition, the PCC MHL clinician should routinely advise the QFMHS-on-call psychiatrist of any other police negotiator incidents that may warrant additional input or clinical input from the psychiatrist.

- Handovers should occur via phone and written notice (email summary or clinical note summary) which details the relevant information for the QFMHS-on-call psychiatrist.

Response

The role of the PCC MHL clinicians / QFMHS-on-call psychiatrist in providing support is primarily to share information and liaise with the local Authorised Mental Health Service (AMHS). ***Attachment A*** outlines information that may be shared.

Key roles at this stage include:

- Provision of general advice regarding mental illness and drugs and alcohol issues
- Obtaining and sharing relevant collateral and historical information under MOU
- Liaison with local AMHS
    - Local AMHS to undertake assessment and provide follow up treatment and care when indicated

During business hours (8:30AM – 4PM, Monday – Friday), the local AMHS Mental Health Intervention Coordinator (where available) should be contacted by the PCC MHL clinician to ensure linkage with local police and mental health collaborative programs (e.g. MHIC program, co-responder programs). If there is no local police and mental health program in operation within the relevant AMHS catchment area, the Acute Care Team should be contacted.

The AMHS and the PCC MHL clinician or QFMHS-on-call psychiatrist should work collaboratively to gather information and facilitate service provision within the local AMHS if required (e.g. assessment and/or admission to the mental health unit)

Escalation

There are a range of factors that may indicate that a Negotiation Incident requires a system level response and coordination across multiple mental health services to be provided in order for the police negotiators to be appropriately supported. Relevant considerations include:

- the complexities arising from the incident (clinical, risk, other – such as Mental Health Act or victim related issues)
- media attention that may require Department of Health advice and response
- requirements for linking with additional resources
- systemic issues
- Queensland Fixated Threat Assessment Centre (QFTAC) or Counter-Terrorism matters.

If a Negotiation Incident is escalated, the Statewide Director for QFMHS (during business hours) and the Chief Psychiatrist-on-call (after business hours) should be advised by the on-call-psychiatrist.

If the PCC MHL clinician responded to the police negotiator request for support, they must liaise with the on-call-psychiatrist regarding the need for escalation to the Statewide Director or Chief Psychiatrist.

After escalation, the QFMHS-on-call psychiatrist may continue to act as the contact for the police negotiators, unless it is determined otherwise through consultation with the Statewide Director or Chief Psychiatrist.

Additional Response

The role of the QFMHS-on-call psychiatrist, the Statewide Director of QFMHS or Chief Psychiatrist-on-call at this stage reflects a need for a system level response and coordination across multiple services to be provided in order for the police negotiators to be appropriately supported.

In addition to the roles articulated in the initial response, key roles include:

- Liaising with the Office of the Chief Psychiatrist regarding any incidents that may result in significant systemic and/or media issues
- Facilitating linkage with other QFMHS programs such as QFTAC
    - Other QFMHS programs to provide additional input when indicated
- Facilitating linkage with the local AMHS

- Local AMHS to undertaken assessment and provide follow up treatment and care when indicated

The Clinical Director of the AMHS should be contacted to ensure that additional levels of local support are able to be provided.

A collaborative response, which includes the QFMHS-on-call psychiatrist, the Statewide Director of QFMHS or Chief Psychiatrist-on-call providing assistance and support to the AMHS as required during this incident, should occur (e.g. liaison with police, advice regarding the model of service, etc.).

Resolution

The PCC MHL clinician or QFMHS-on-all psychiatrist has specified roles under this model of service once a matter has been resolved. These roles are to:

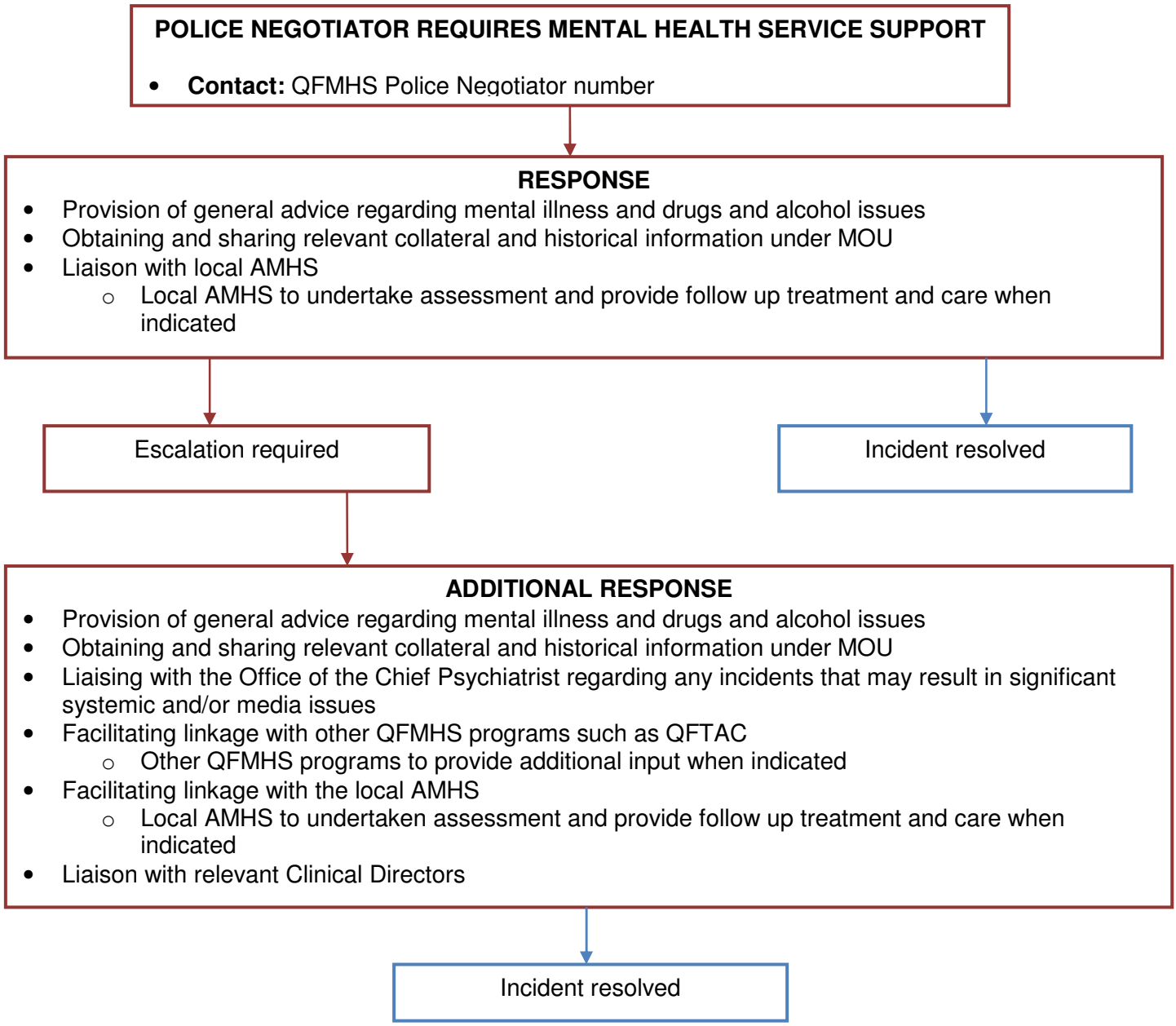
- continue to liaise with AMHS to provide support and advice as required
- participate in QFMHS local review processes for the PCC MHL clinicians and psychiatrist involved.

The local AMHS will have ongoing responsibility for following up individuals involved in a Negotiation Incident as appropriate. In addition, the AMHS staff involved in providing support to police negotiators should participate in local review processes.

A number of additional actions may be required post-resolution of the Negotiation Incident; including development of a Police and Ambulance Intervention Plan (if appropriate) and updating alerts on CIMHA. Although the local AMHS should take the lead in these actions, the PCC MHL clinician and/or QFMHS-on-call psychiatrist should be available to provide advice and support if required.

If systemic issues are identified by the QFMHS-on-call psychiatrist or the PCC MHL clinician during the Negotiation Incident, these should be escalated to the Statewide Director of QFMHS and the Operations Manager of QFMHS for follow up as appropriate. If systemic issues are identified by AMHS staff, these matters should be escalated through existing local escalation processes (e.g. to the Clinical Director, Executive Director or Operations Manager).

Figure 2: Model of Service



Additional mental health services role:

- Input into training/education – police and mental health services
- Service development and research
- Involvement in critical incident reviews

Circumstances in which mental health service support may be indicated

Mental health support of the police negotiator program may be indicated in any circumstances in which police negotiators are involved in responding to a crisis. To this end, the need for mental health support is primarily identified by the police negotiator unit of the QPS. The types of circumstances in which mental health service support may be indicated include:

- the circumstances of the event leads police negotiators to consider the matter may involve a person with a mental illness, or the person may be experiencing a mental health crises
- on initial reviews by the police, the person is listed on the police system (QPRIME) as having a mental health history
- a police communications centre referral to the PCC MHL service establishes that the person is a current or former patient of mental health services.

Information sharing

Information that is shared by clinicians providing support to police negotiators must be provided in accordance with the *Hospital and Health Boards Act 2011* (HHBA). The HHBA provides legislative authority under which the HHS clinicians can access and disclose, under relevant circumstances, clinical information. In accordance with Part 7 of the HHBA, confidential information may be disclosed under certain circumstances. These 'confidentiality' provisions apply to the model of service for providing mental health service support to police negotiators.

The *Hospital and Health Boards Regulation 2012* prescribes a Memorandum of Understanding (MOU) which provides the primary mechanism under which information is shared between QH and the QPS in respect of mental health crises occurring in the community. This MOU - *the Memorandum of Understanding between the State of Queensland through Queensland Health and the State of Queensland through the Queensland Police Service, Mental Health Collaboration 2016* – enables clinicians providing support to the QPS to provide health information as part of that support. Relevantly, the MOU permits the disclosure of confidential information by delegated QH staff (including clinicians) in circumstances where there is a mental health crises situation. The information that can be shared under the MOU is listed at Appendix A.

Staff providing information to the QPS under this model of service will primarily seek information through accessing the Consumer Integrated Mental Health Application (CIMHA); the Queensland statewide mental health information system. Information on this system is essentially limited to services provided by QH public sector mental health services. Information will also be able to be obtained about QH public sector alcohol and drug treatment services through the QH ATOD-IS information system.

In addition, limited consolidated clinical information from other QH information systems may be accessed by the QFMHS staff (by way of The Viewer). This information is also essentially limited to information that is recorded by Queensland public sector health services.

There is information that is outside the scope of the information systems to which the staff operating under this model of service will have access, and therefore, will not be able to be provided to QPS, this includes:

- private mental health service or other health records
- general practitioner records
- department of defence health records, and
- interstate mental health service records.

Workforce and hours of operation

It is intended that the service be available at any time a police negotiator identifies that mental health service support would be of assistance in resolving a mental health related crisis in the community. That is, the service operates on a 24/7 and statewide basis.

The provision of support to police negotiators leverages off existing mental health services within the QFMHS and HHSs and augments these with a specialist on-call forensic psychiatry service located within the QFMHS and an expanded role for the PCC MHL service.

This on-call forensic psychiatry service and expanded PCC MHL service role is intended to be available to support AMHS staff statewide, including outside of South East Queensland, through the use of telephone or videoconference as required. All QFMHS-on-call psychiatrists working under this model will have access to CIMHA.

Operationally, the statewide service will be achieved through the establishment of a dedicated phone line that is managed as below:

- PCC clinician – 08:00 to midnight (Monday to Saturday[19]and 12:00 to 20:00 Sunday)
- QFMHS-on-call psychiatrist roster – Midnight to 08:00 (Monday to Saturday and 20:00 to 08:00 Sunday).

Through the use of this dedicated phone line, mental health service support will be able to be provided to police negotiators at any time of the day, seven days a week.

Clinical and operational governance

The PCC clinicians and on-call psychiatrists working under this model of service are supported by the Director of QFMHS and the Operations Manager of QFMHS.

A dedicated steering group consisting of representatives from the QFMHS and the QPS will meet on a tri-annual basis, or more frequently if required, to discuss complex cases and operational learnings.

Systemic issues will be referred from this steering group when required to the QPS and QH (mental health) committee which has executive membership from the Mental Health Alcohol and Other Drugs Branch, the QFMHS and the QPS.

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[19] This is contingent on the expanded PCC MHL service model operating seven nights a week and on weekend days.

Program linkages

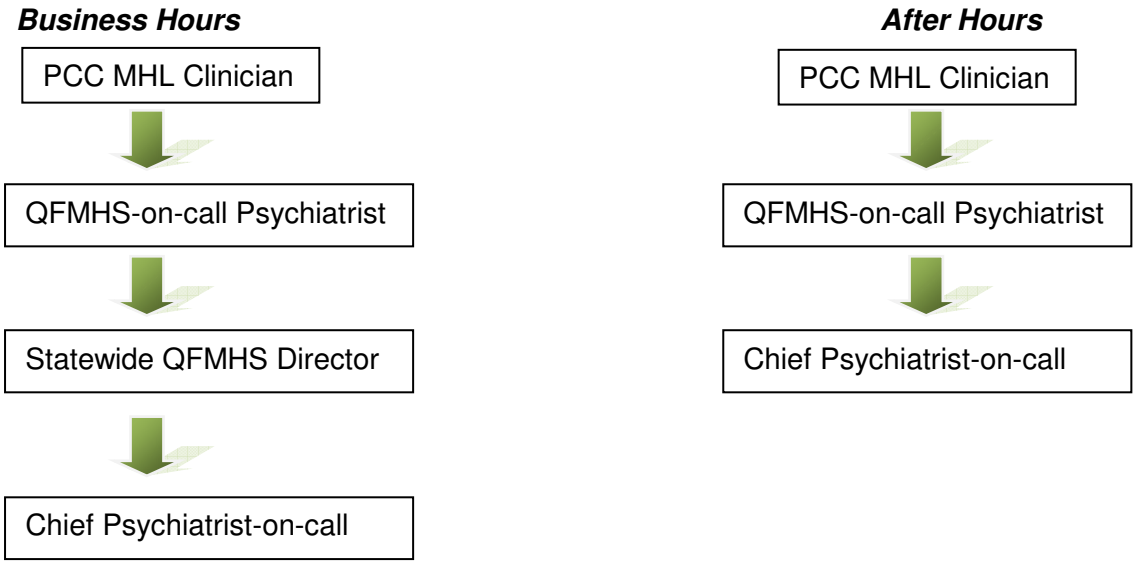
Within this model of service delivery it is recognised that linkages will need to occur across programs within the QFMHS, including the PCC MHL service, QFTAC and the Court Liaison Service. Linkages will also need to occur across the QFMHS and AMHS programs, in particular those programs that support police and mental health collaboration (e.g. co-responder programs and the Mental Health Intervention Coordinator program).

The QPS and QH (mental health) committee with have operational oversight of the strategic and program linkages across the range of QH and QPS collaborative programs. Clinically, it is expected that linkages within the QFMHS and across HHSs will occur through good communication practices and documented recording of referrals (where required) in CIMHA.

Escalation pathways

An escalation pathway for the PCC MHL Clinicians and QFMHS on-call psychiatrists will operate to support staff during the provisions of mental health support (e.g. at the time of the incident).

This pathway operates as below:



Education and Training

Education and training to support the model of service for police negotiators and mental health services operates to, enhance the knowledge and understanding of police negotiators in relation to mental health services and the mental health system; and ensure clinicians working with the police are cognisant of police negotiator practices and their role in supporting the functions of police.

Key training elements for staff working under this model of service includes:

- Annual model of service delivery training for QFMHS staff
- Police negotiator scenario training
- Peer-review, including:

- inclusion of a police negotiator case as part of the regular QFMHS Consultant reviews
- learnings from cases presented to the dedicated steering group being shared and reviewed.

Introductory sessions on the model of service delivery would be beneficial for HHS staff working as Mental Health Intervention Coordinators, in co-responder programs or in Acute Care Teams.

The provision of training regarding police negotiator practices to QFMHS on-call psychiatrists, the PCC MHL clinicians, and key AMHS staff, who can then provide support and work collaboratively with other AMHS clinicians, maximises the capacity for mental health support to be provided across the mental health system.

Review

The effectiveness of this model of service is to be reviewed after 12 months. The steering group will take carriage for ensuring the model is reviewed.

In addition to considering the overall effectiveness of the model of service, the review should collect data on the type of support provided at each Police Negotiation incident involving mental health services to support the review process.

Appendices

Appendix A

Information that can be shared under the *Memorandum of Understanding between the State of Queensland through Queensland Health and the State of Queensland through the Queensland Police Service, Mental Health Collaboration 2016.*

The following information may be disclosed, where relevant, by Queensland Health staff to a QPS officer, including a police negotiator, during an incident where a police negotiator requires mental health support:

- name
- date of birth
- address
- contact details
- the nature of the person's mental illness
- a description of the characteristics of a mental illness
- clarification that the behaviour being demonstrated by the person is not indicative of mental illness
- intoxication from substances and/or alcohol;
    - behaviour to expect in these circumstances
    - impact on behaviour, and
    - propensity of verbal/aggression towards others and/or harm to self
- medical history/chart information including recent behaviour, most recent assessment and expected responses
- details of relevant health professionals, for example, mental health clinician, psychiatrist or treating doctor
- any relevant significant risk factors, including the propensity for violence or self harm
- history of possessing firearms, dangerous weapons or drugs
- the person's medication (including effects of medication and of non-compliance)
- warning signs indicating deterioration in the person's mental health
- 'triggers' that may escalate the incident
- suicide risk;
    - previous suicidal ideation or attempts to commit suicide
    - lethality of previous suicide attempts
- self harm behaviours and propensity to act in relation to self-harm thoughts
- details of
    - next-of-kin and carers
    - any person nominated as a contact in the event of a crisis situations

- content of any Police and Ambulance Implementation Plan applicable to the person.

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